**Blood Bank Staff Meeting 10.4.23**

1. **EVENTS**:
   1. FDA Reportable:
      1. A unit of RBCs was issued for the plasma order.
   2. IQEs:
      1. A homozygous cell was used for QC. X2
      2. The probe was out of the glycerol bottle which caused the reading on the chart to be inconsistent.
      3. Pending IQEs need to be investigated.
   3. OnPoint Events:
      1. Discrepant Information –
         1. Total of 10 OnPoint Events due to discrepant information.
            1. Email was sent to the nurse manager, Maureen Jordan (Chief Operating Officer), Jill Stunkard (Chief Nursing Officer), Gina Marone (Chief Nurse Executive), lab leadership team for their attention and to obtain a follow-up from the nursing.
         2. External On Points –
            1. The physician requested a unit of plasma on the wrong patient.
            2. A unit of whole blood was wasted after issuing due to patient passed away.
            3. No Patient identification label was present on the blood bank slip.
            4. A unit of cryoprecipitate was wasted due to attempt of transfusing the unit just prior to plasmapheresis.
            5. A unit of cryoprecipitate was ordered but not picked up by the floor.
2. **Employee Survey:** 
   1. **Employee Recognition:** 
      1. Day-to-day recognition will be given to the tech who go above and beyond.
      2. Consider giving a kudos to your coworker for helping you on day to day job.
         1. By placing a note on the bulletin board.
         2. By bringing it to the supervisor’s attention for their recognition.
   2. **Safety Concerns:** 
      1. Hospital management seems interested in patient safety only after an adverse event happens:
         1. Bring safety concerns to the supervisor.
         2. Place an OnPoint anonymously if preferred.
3. **Responding to Trauma:** 
   1. **DO NOT** take more products than our policy states.
      1. **WB, 1 O+, and 1 O-**
      2. **2 O+ and 2 O-**
4. **Hours of work:** 
   1. DO NOT leave the lab until after the staff from the following shift has arrived and all the necessary information has been communicated.
   2. Failure to follow will result in disciplinary action.
5. **Annual Mandatory Training:**
   1. Due on 10/9/23. If you have not completed it, please do so NOW.
6. **Elkins Park Orders for transfusion:**
   1. What changed?
      1. Blood Bank Techs will call Omni to transfer the blood products to Elkins Park.
7. **Cryoprecipitate order:** 
   1. Minimize wastage by confirming with the nurse prior to thawing product.
   2. Ask specifically if they will be ready for transfusion in 25 minutes.
8. **Exsanguination TAT:** 
   1. TAT for EP is 15 minutes.
      1. Prepare products RIGHT AWAY.
   2. Everything should be documented appropriately.
      1. Date and **Time** of EP activation.
      2. Date and **Time** of release of EP Pack.
      3. The **name** of the physician activating an EP.
   3. **Use the Exsanguination Protocol Form if there is no time to document everything in different places.**
   4. This information is monitored by the blood bank quality program.
   5. Continuing to fail to document this information may result in disciplinary action.
9. **Errors on Vision:** 
   1. Document all Vision errors on the Vision Problem Log (BBQC01-005 Form C).
   2. This log is used to track the errors and avoid a bigger issue from occurring.
10. **No food or drink in the lab:** 
    1. Please DO NOT eat or have any food or drink out in the lab.
    2. Disciplinary action will be taken for those who do not follow this instruction.